Wisconsin Health Insurance Risk Sharing Plan (HIRSP)
6406 Bridge Road, Suite 18 • Madison, WI 53784-0018
(800) 828-4777 (toll free in Wisconsin) or (608) 221-4551 (Madison area and out of state)

Application for Temporary Wisconsin Medicaid Certification

Please complete this application for whoever performed or will perform medical services on a HIRSP policyholder. Each individual provider is required to complete a separate application. This is necessary in order to bill for HIRSP services. Please print all answers and return the form to the above address. For any questions about this application, please call HIRSP at the numbers listed above.

Additional copies may be printed from the HIRSP Web site at ***www.dhfs.state.wi.us/hirsp/certification/certification.htm*** or by calling HIRSP at the above telephone numbers.

In order to be reimbursed for services provided, HIRSP must receive correct and complete claims, including resubmissions and adjustments, within 15 months from the date the service was rendered.

Important: For a provider to bill for services, the provider must submit to HIRSP copies of the provider's current license(s), approval(s), or certification(s). (See indicators in "Key" and "Required Materials" column on reverse side of this application for requirements.) Please attach required copies to this application.

Provider Physical Address

1. Full Name _____
2. Physical Address (where services are rendered)
_____
_____
_____
_____
3. Telephone ( ) _____

Provider Billing Address

1. Full Name _____
2. Billing Address (where checks are to be sent)
_____
_____
_____
_____
3. Telephone ( ) _____

4. Provider's ☐ Federal identification/IRS number _____
☐ Social Security number _____

5. Medicare number _____ Medicaid number _____ Number of beds _____

Unique Physician Identification Number (UPIN) _____ Fiscal Year _____

6. Do you perform any lab tests? ☐ Yes ☐ No
If yes, attach a copy of the HCFA letter with your assigned Clinical Laboratory Improvement Amendment (CLIA) number. Required for all providers except hospitals.

7. Do you want to receive a copy of the HIRSP provider handbook? (The handbook is also available at ***www.dhfs.state.wi.us/hirsp/provider/handbook.htm***.) ☐ Yes ☐ No

8. ***Please complete reverse side. Indicate your provider type/specialty by circling the correct description(s) or explain your services in detail if not listed.***

I affirm that services provided are medically indicated and necessary to the patient's health. The services are within the scope of my (our) licensure. I understand that any false claims, settlements, documents, or concealment of material fact may be prosecuted under applicable federal and state law. I further affirm that to the best of my knowledge the information presented here is accurate and complete.

Signed _____ Date _____
(Signature must be that of the individual provider or the authorized agent for an institution.)

Types/Specialties		Required Materials
25.	Ambulance, Land or Air	A
42.	Ambulance, Land or Air	A
70.	Ambulatory Surgery Center	B
43.	Anesthetist (not an M.D.)	A
37.	Audiologist	C
30.	Chiropractor	A
27.	Dentist	A
73.	End Stage Renal Disease	B
44.	Home Health Agency	B
95.	Hospice	B
61/62.	Hospital, General Inpatient/Outpatient	A, & C or D
64.	Hospital, Institution for Mental Disease/Psychiatric	A
58.	Individual Medical Supply, Specialty _____ ***(e.g., Individual Orthotist, Individual Prosthetist)***	C
23/69.	Laboratory/Independent Lab	B
23/66.	Laboratory/Physician Lab (clinic or hospital)	A
31/62.	Licensed Psychologist (with doctoral degree)	A
20.	M.D., Specialty _____ ***(e.g. General Practice, Psychiatry. If specialty is psychiatry, send proof of completed residency.)***	A
54.	Medical Vendor (Medical Equipment/Supplies)	C
45.	Nurse Practitioner	A & C
33.	Nurse Services, Specialty _____ ***(e.g., RN, LPN, Respiratory Care)***	A
80.	Nursing Facility. ☐ Skilled, or ☐ Institution for Mental Disease	A
35.	Occupational Therapy	C
29.	Optician	C
28.	Optometrist	A
19.	Osteopath, Specialty _____ ***(e.g., General Practice, Psychiatry. If specialty is psychiatry, send proof of completed residency.)***	A
26.	Pharmacy	A
34.	Physical Therapy	A
32.	Podiatrist	A
75.	Portable X-ray Supplier	B
65.	Rehabilitation Agency	B
36.	Speech & Hearing Clinic	D
78.	Speech Pathology/Therapy (B.S. or M.S. degree)	D

Other. Explain below, and submit A-D or your state's requirements.

_____

_____

_____

Key for Required Materials

Attach to data sheet the required copies as indicated:

A = Copy of license.

B = Copy of Medicare certification approval.

C = Copy of approvals/certifications from appropriate associations and organizations (e.g., ASHA, ABC, etc.).

D = Copy of approval by Joint Commission on Accreditation of Healthcare Organizations.

INSTRUCTIONS FOR COMPLETION OF THE WISCONSIN HEALTH INSURANCE RISK SHARING PLAN (HIRSP) APPLICATION FOR TEMPORARY WISCONSIN MEDICAID CERTIFICATION

The Wisconsin Health Insurance Risk Sharing Plan (HIRSP) reimburses for covered services provided by Wisconsin Medicaid-certified providers. HIRSP offers temporary Wisconsin Medicaid certification for providers located outside Wisconsin that provide services to HIRSP policyholders. Temporary certification lasts for one year but may be renewed by the provider.

HIRSP requires information to enable Wisconsin Medicaid to certify providers and to authorize and pay for medical services provided to eligible HIRSP policyholders. Personally identifiable information about HIRSP providers is used for purposes directly related to HIRSP administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form will result in denial of HIRSP payment for the services.

If approved, temporary certification begins the earlier of the following:

- The date of service (DOS) of a claim for a HIRSP policyholder.
- The date HIRSP receives the Application for Temporary Wisconsin Medicaid Certification.

If the provider is requesting certification for a specific DOS, provide that date, the policyholder's name, and the HIRSP identification number at the top of the front page of the application. If the provider has claims associated with this request, attach them to the application. Providers are required to submit claims to HIRSP within 15 months following the date the services were provided.

Complete the attached Application for Temporary Wisconsin Medicaid Certification by answering all the questions. The following are instructions to help you complete the application accurately and completely.

Provider Physical Address

The provider's physical address is the location where services were provided. It may be a hospital, a doctor's office, or a clinic that is affiliated with a hospital. Provide information for one provider only. If additional providers need certification, they are required to submit separate applications to HIRSP. Provide the provider's name, physical address, and telephone number where HIRSP may contact the provider at the location the services were provided.

1. Fill in the full name of the provider who rendered services and is requesting certification.
2. Fill in the street address for the provider's primary physical location. This address cannot be a post office box.
3. Fill in the telephone number, including area code, where the provider's physical location may be reached.

Provider Billing Address

The provider's billing address is the location where the provider's billing office is located. It may be a hospital, the doctor's office, or the central location for a group of affiliated providers.

1. Fill in the full name for the provider's billing address that is the same as the name registered with the Internal Revenue Service (IRS) for the provider's Federal Identification Number (FIN) or Social Security Number (SSN).
2. Fill in the address for the provider's billing office. This address may be a physical street address or an assigned post office box number.
3. Fill in the telephone number, including area code, where the provider's billing address may be reached.

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4. Fill in the provider's FIN/IRS number assigned to the name that corresponds with the provider's billing address. If the provider does not have an FIN/IRS number, the provider is required to provide his or her SSN.
5. If applicable, fill in the provider's Medicare number, Wisconsin Medicaid number, number of beds, Unique Physician Identification Number (UPIN), and provider's fiscal year end.
6. **Complete only if you are an independent laboratory (provider type 23, specialty 69).** Attach to your application a copy of the letter from the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, with your assigned Clinical Laboratory Improvement Amendment (CLIA) number.
7. You may obtain more information about HIRSP on the HIRSP Web site at *www.dhfs.state.wi.us/hirsp/* or by contacting HIRSP Customer Service at (800) 828-4777 or (608) 221-4551.
8. On the reverse side of the application, circle your applicable provider type and specialty. Submit with this application the required materials indicated by the letters in the right column. A key to these letters appears on the bottom of the page. Without these required materials, Wisconsin Medicaid will be unable to certify you for HIRSP reimbursement.

Signature

Sign and date the application in the box at the bottom of the front page. To be eligible for certification, HIRSP requires the form be signed by the individual provider or the provider's authorized agent.